Welcome to Hudec Dental Today's Date:____/____/____

Patient Information

First:____________________ M:____ Last:____________________ Preferred:________________

Date of Birth:____/____/_____ SSN:____-____-_____ License #:_________Sex: ☐ M ☐ F

Street Address:______________________________ Apt:_____ City:____________________

State:____ Zip:_________ Email:____

Primary Phone:(____) ____-_____ ☐ Mobile ☐ Home ☐ Other

Secondary Phone:(____) ____-_____ ☐ Mobile ☐ Home ☐ Other

Would you like to receive appointment reminders via text? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married

Emergency Contact:______________ Relationship:____________Phone: (____) ____-_____

Student Status if Dependent is Over 19 Years Old (For Insurance)

☐ Full-Time Student ☐ Part-Time Student ☐ Non-Student

Guarantor or Responsible Party Information *(If different from patient)*

Name:________________________________ Relationship to Patient:____________________

Date of Birth:____/____/_____ SSN:____-____-_____ License #:_________Sex: ☐ M ☐ F

Street Address:______________________________ Apt:_____ City:____________________

State:____ Zip:_________ Email:____

Primary Phone:(____) ____-_____ ☐ Mobile ☐ Home ☐ Other

Insurance Information

Insurance Company:________________________

Group Number:____________________________

Member ID:_______________________________

Employer:________________________________

Policy Holder Name:_______________________

Policy Holder Date of Birth:____/____/_____

Policy Holder SSN:____-____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Insurance Company:________________________

Group Number:____________________________

Member ID:_______________________________

Employer:________________________________

Policy Holder Name:_______________________

Policy Holder Date of Birth:____/____/_____

Policy Holder SSN:____-____-_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Health History

Although dental personnel primarily treat the area in and around your mouth, it is part of your entire body. Health problems or medications could significantly affect the dental care you receive.

Are you allergic to the following? ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Sulfa ☐ Iodine ☐ Metals ☐ NSAIDs *(Ibuprofen, Naproxen, Aspirin)* ☐ Opioids *(Percocet/Oxycodone, Vicodin/Hydrocodone, Morphine)* ☐ Barbiturates

Allergies not listed:____

Please list any medication/supplements you take

____

____

____

____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco or nicotine products? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Pregnant/trying to get pregnant? ☐ Yes ☐ No

Taking oral contraceptive? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:____________________

____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:____________________

____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain:____________________

Do you have, or have you had, any of the following? (Please check next to all that apply)

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Anxiety
☐ Any type of Transplant
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Birth Defects
☐ Blood Disease
☐ Blood Disorders
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ COPD
☐ Cortisone Medicine
☐ Depression
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Gastrointestinal Disease
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Skin Rash
☐ HPV
☐ Hypoglycemia
☐ Infective Endocarditis
☐ Intellectual Disability
☐ Irregular Heartbeat
☐ Jaw Joint Pain
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Migraines/Headaches
☐ Mitral Valve Prolapse
☐ MRSA
☐ Pacemaker
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Persistent Cough
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Rheumatism
☐ Seizures
☐ Scarlet Fever
☐ Shingles
☐ Shortness of Breath
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Sleep Apnea
☐ Spina Bifida
☐ Steroid Treatment
☐ Stomach Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis (TB)
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Any serious illness(es) not listed above?:________________________________

____________________ ____________________ _____/_____/_____

Print Name *Signature* *Today's Date*

(Parent or Guardian must sign if patient is a minor)

Dental History

Patient Name:____Date of Birth:____/____/_____

What brought you in today? ☐ Exam/hygiene evaluation ☐ Pain/Problem tooth ☐ Other:____________________

When was the last time you visited a dentist?______________ Name:______________________________

When was your last full set of dental x-rays?____________ (Do you have copies if less than one year? ☐ Y ☐ N)

Have you ever had an oral cancer screening? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No

Have you been previously diagnosed with periodontal disease? ☐ Yes ☐ No

Have you ever had prolonged bleeding after an extraction? ☐ Yes ☐ No

Have you had any problems with past dental treatment? ☐ Yes ☐ No

Do you currently wear removable full/partial dentures? ☐ Yes ☐ No approximately how old?_______________

Do you have any problems associated with movement of the lower jaw such as clicking, popping, pain, or locking when open? ☐ Yes ☐ No

Do you have sores, lumps or growths in or near your mouth? ☐ Yes ☐ No

Do you clench your teeth? ☐ Yes ☐ No If yes, Do you wear a night guard? ☐ Yes ☐ No

Do you play contact sports? ☐ Yes ☐ No If yes, Do you wear a mouth guard? ☐ Yes ☐ No

Do you currently have the following? ☐ Swelling ☐ Bleeding Gums ☐ Loose Teeth ☐ Bad Breath

Have you ever been diagnosed or treated for TMD *(Temporomandibular Joint Dysfunction)*? ☐ Yes ☐ No

Do you want your teeth straighter? ☐ Yes ☐ No

Are there any cosmetic changes you would like to have done? ☐ Yes ☐ No

What would you like to change about your smile? ☐ Bite ☐ Chipped Teeth ☐ Spaces
☐ Crowding ☐ Smile Make Over ☐ Missing Teeth ☐ Whiter Teeth

Comments to any yes's checked above:____

____

NEW PATIENTS

How did you hear about Hudec Dental? ☐ Insurance Company ☐ Internet ☐ Employer
☐ Drive-by ☐ Family/Friend ☐ Other ________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

________________________________ ______________________________ _____/_____/_____

Print Name *Signature* *Today's Date*

(Parent or Guardian must sign if patient is a minor)

Patient Code of Conduct

To provide a safe and healthy environment for staff, patients, and their families, Hudec Dental expects all visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before leaving the office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing it away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Possessing firearms or any weapon.
- Intimidating, harassing, or using profanity toward staff or other patients.
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication.
- Physically assaulting or threatening to inflict bodily harm.
- Making verbal threats to harm another individual or destroy property.
- Damaging business equipment or property.
- Making menacing or derogatory gestures.
- Making racial or cultural slurs or other derogatory remarks.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Our doctors and hygienists want to be available for your needs and the needs of all patients. When a patient does not show up for a scheduled appointment another patient loses the opportunity to be seen.

Any appointment canceled within 48 hours, late arrival and/or failing to show up will be considered a broken appointment and a $25 fee may be charged. We reserve the right to reschedule your appointment or decrease appointment time if you arrive late.

If you miss more than three appointments without prior notice, we may regrettably have to refer you to another dental practice for your dental care.

I acknowledge that I have read the above and understand the consequences and my responsibilities.

______________________________	______________________________	_____/_____/_____
Print Name	*Signature*	*Today's Date*

(Parent or Guardian must sign if patient is a minor)

VELscope Oral Cancer Screening Consent Form

Risk Factors of Oral Cancer that are controllable and uncontrollable would be tobacco use, excessive alcohol consumption, using both tobacco and alcohol, excessive unprotected sun exposure, HPV viral infection, race, ethnicity and economics, high risk of cancer recurrence, gender, and age.

Signs & Symptoms

Early Indicators are red and/or white discoloration of the soft tissues of the mouth, any sore that does not heal within 14 days, and hoarseness which last for a prolonged period.

Advanced Indicators would be sensation that something is stuck in your throat, numbness in the oral region, difficulty in moving the jaw or tongue, difficulty in swallowing, ear pain that occurs on one side only, being sore under a denture that won't heal, even after adjustment of the denture, or a lump or thickening which develops in the mouth or on the neck.

Oral Cancer Statistics

Each year in the US alone, approximately 34,000 individuals are newly diagnosed with oral cancer. The death rate from oral cancer is very high; about half those diagnosed will not survive more than 5 years. With early detection, survival rates are high, and side effects from treatment are at the lowest.

Get it early. Get it All-VELscope

Our practice believes in early detection of oral cancer. We can now offer you a state -of-the-art cancer exam called the VELscope Oral Cancer Screening System. As always, we will continue to provide conventional oral screening exams, however now we are able to do even more!

About the VELscope Exam:

- The exam takes approximately 3-5 minutes.
- The exam is comfortable and pain-free.
- Completely safe to perform.

The VELscope peace-of-mind evaluation is available to you for $24.00.

________ I accept VELscope evaluation.

________ I have read the above information with regard to the potential knowledge available through the VELscope evaluation. At this time, I am choosing to decline this form of oral cancer screening.

______________________________	______________________________	_____/_____/_____
Print Name	*Signature*	*Today's Date*

(Parent or Guardian must sign if patient is a minor)

Financial Policy Notice and Disclaimer

At Hudec Dental, our priority is to deliver exceptional care and service to all our patients. We believe it's essential for you to have a clear understanding of our financial policies. Should you have any questions, please feel free to ask any of our staff members for clarification. Thank you for choosing Hudec Dental.

Minor Patients

Responsibility for minors' rests with the adult accompanying the patient at the time treatment is provided regardless of any court ordered arrangements. A parent or legal guardian must be present to sign a treatment consent form for all patients under the age of 18.

Personal Payments

Patients are responsible for their charges at the time the service is provided. We accept major credit/debit cards (Visa, Master Card, Discover, Amex) and checks with personal identification. Effective January 1, 2024, all credit card charges will incur a 3% convenience fee. The convenience fee does not apply to debit card charges or payment by check.

Financing Options

We are happy to offer our patients monthly payment plans through Care Credit. We participate in both extended payment and interest free options upon approval through Care Credit. Please feel free to request more information about this option.

Additional Information

There will be a charge of $30 for each invalid or NSF check. Any NSF account remaining unpaid after 10 days will be turned over to collections. Past due accounts will be turned over to a collection agency, which may result in additional fees incurred. In the event a refund is due, payment will be given within 2 weeks and refunded in the form in which it was originally received. There will be a 5% processing fee deducted for check refunds initially made with a credit card. Lab fees for all incomplete treatment are non-refundable. Unopened products can be returned in the original packaging within 15 days for a full refund.

Insurance Coverage

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company PRIOR to any treatment being performed. Understand your insurance coverage is a contract between you and your insurance company. You are responsible for any portion of your bill not covered by your insurance. Co-pays and deductibles are due at the time of service. We will bill your insurance company for services performed and provide any necessary documentation as a courtesy.

I hereby authorize Hudec Dental to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I also authorize the use of this signature to furnish all medical records pertaining to the treatment. I further authorize payment directly to my doctor for the services performed.

______________________________	______________________________	_____/_____/_____
Print Name	*Signature*	*Today's Date*

(Parent or Guardian must sign if patient is a minor)

Hudec Dental

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

- **Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment for you.
- **Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.
- **Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health decisions for you, we will treat the patient representative the same way we would treat you with respect to your health information.
- **Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Public Health Activities:** We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.
- **Security of HHS:** We will disclose your health information to the Secretary of the U.S Department of Health and Human Services when required to investigate or determine compliance with HIPPA.
- **Worker's Compensation:** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Law enforcement:** We may disclose you PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.
- **Health Oversight Activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **Fundraising:** We may contact you to provide you with information about our sponsored activities, including fundraising programs as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.
- **Coroners, Medical Examiners and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

OTHER USES AND DISCLOSER'S OF PHI: Your authorization is required, with few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS:
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

- **Disclosure Accounting:** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
- **Right to Request a Restriction:** You have the right to request additional restrictions on our use or disclosure of you PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
- **Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why denied it and explain your rights.
- **Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.
- **Electronic Notice:** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email)

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIPAA Privacy Sheet
I acknowledge that I have received a copy of the HIPPA privacy sheet

Patient Initials_______________

CONTACT INFORMATION
Our Privacy Official: HR Generalist
Telephone: (216) 485-5788
Address: 6700 West Snowville Road. Brecksville, Ohio 44141
Email: hr@hudecdental.com

2010, 2013 American Dental Association. All Rights Reserved. Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association. This form is educational only, does not constitute legal advice, and covers only federal, not state, law.

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and the primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide information for ALL individuals you want us to be able to speak with.

Spouses are NOT automatically included; their names must be explicitly stated below.

You may opt out by checking the "DO NOT Release Information" box below.

Who can information be released to?

Full Name:________________________________

Relationship:______________________________

Phone Number:____________________________

What type of information can be released?

☐ Appointments

☐ Financial Information

☐ Dental Treatment

☐ Other:______________________________

Who can information be released to?

Full Name:________________________________

Relationship:______________________________

Phone Number:____________________________

What type of information can be released?

☐ Appointments

☐ Financial Information

☐ Dental Treatment

☐ Other:______________________________

☐ DO NOT Release Information

I hereby authorize the above person(s) to have access to Information covered under the Notice of Privacy Practices regarding myself.

____ ____________________________________ _____/_____/_____

Print Name *Signature* *Today's Date*

(Parent or Guardian must sign if patient is a minor)